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Midterm Evaluation Report

Child Survival XIII

ESPERANÇA - PERU

Lead Evaluator:

Dr. Richard Crespo
1600 Medical Center Dr. – suite 1400
Huntington, WV 25701
tel: (304) 691-1193
fax: (304) 691-1183
e: crespo@marshall.edu

Esperança
1911 West Earll Dr.
Phoenix, AZ 85015
tel: (602) 252-7772
fax: (602) 340-9197
Director of Programs: Reese Welsh, MPH
E: reese@esperanca.org

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Mid-term Evaluation

Child Survival XIII
Esperanza, Perú
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1. EXECUTIVE SUMMARY

This project is located in the Southern highland of Perú, in the Department of Apurimac, Cotabambas Province. Identifying the project's location as being in the highlands should be taken literally! The 140 communities served by the project are located between 10,000 and 15,000 feet. They are draped across Andean mountain peaks and require hours of hiking to traverse from one to the other. The people are Quechua speakers; In fact the vast majority of women only speak Quechua. All of the project's field staff are native speakers.

The project has four interventions: pneumonia case management (PCM), diarrheal disease control, nutrition/growth monitoring, and maternal health/obstetrical emergency management. The measurable objectives, along with the baseline data, are listed in the following table.

Table 1: The Project's Objectives and Baseline Data

Objective	Goal	Baseline
1. Children from 0-6 months will receive exclusive breastfeeding.	50%	59%
2. Children from 6 to 24 months will eat solid food, complimented by breast milk.	60%	40%
3. Children less than 2 years of age will receive monthly growth monitoring, as documented by their growth charts.	40%	37%
4. Children 0 to 6 months who have an episode of diarrhea, will receive more breastmilk than usual.	40%	79%
5. Children 6 to 24 months old who have an episode of diarrhea will receive more liquids, including breastmilk and ORS, than usual.	40%	54%
6. Children 6 to 24 months old who have an episode of diarrhea will receive more food than usual for 2 weeks after the episode.	40%	22%
7. Mothers with children less than 2 years of age will be able to recognize two signs of diarrhea.	50%	21%
8. Mothers with children less than 2 years who have diarrhea danger signs will promptly seek appropriate care.	50%	91%
9. Mothers with children under 2 will recognize 2 signs of pneumonia.	50%	16%
10. Mothers with children under 2, who have signs of pneumonia, will promptly seek appropriate care and comply with SCM.	50%	79%
11. Communities will have an emergency transport plan to promptly take sick children to an appropriate care provider when indicated.	80%	NA

12. Pregnant mothers will have 2 doses of tetanus toxiod vaccine document by their maternal health card.	40%	62%
13. Pregnant mothers will have at least two prenatal care visits documented on their maternal health card.	40%	63%
14. Women of childbearing age will be able to recognize 3 signs of obstetrical emergencies.	50%	NA
15. Communities will have an emergency transport plan to promptly take women with obstetrical emergencies to appropriate care.	80%	NA

The main accomplishments of the project are as follows.

1. The project staff have developed an excellent working relationship with the Ministry of Health (MINSA). While the quality of the relationships vary from health center to health center, in all cases the staff have a good working relationship. The relationships with the MOH at the Department (State) level are excellent. A strong bond of mutual respect and trust exists on both sides. The MOH has asked Esperanza to expand their involvement in other provinces of Apurimác Department.
2. Mothers in all 140 communities have been reached with the planned interventions. This is commendable given how difficult it is to reach the target communities and that the only way to reach most of the communities is on foot.
3. Mothers know the sign of rapid breathing at rest as a risk for pneumonia. The project staff have done a good job in overcoming language and cultural barriers to communicate this concept.
4. The current team of field workers (called Supervisors in this project) is well qualified and they work as a team. The Project Director has provided excellent leadership in this project. It has been difficult to find the right staff, because the working conditions are so arduous. The reason that mothers know a sign of pneumonia is because of their diligence in visiting mothers in their homes. Esperanza should do all that it can to support this team and sustain their motivation for continuing.
5. All of the Promoters have been trained in PCM and know the signs of pneumonia.
6. Ninety four percent of the 221 mothers who were interviewed rated the Promoters' work as either satisfactory or good. This indicates that they have a high level of acceptance in their communities.
7. Esperanza's local partner, CADEP, has improved its ability to administer this project. Many of the administrative problems that existed at the beginning of the project have been solved.
8. The project staff have trained MOH personnel in each local health center in the project's interventions and has helped them set up a PCM system in their clinics.
9. The three health committees that have been formed are well motivated and can clearly articulate their responsibilities.

2. ASSESSMENT OF PROGRESS

A. Technical Approach

The project is located in the Southern highland of Perú, in the Department of Apurimac, Cotabambas Province. The 140 communities that are served by the project are located

between 10,000 and 15,000 feet. The people are Quechua speakers; in fact the vast majority of women only speak Quechua. All of the project's field staff are native speakers.

For the lead evaluator, the conditions in which people live is like going back in time 20 years to the high Andes of Ecuador. The people are isolated and have minimal contact with the outside world. They have minimal access to health care. The infant and maternal mortality rates are those of twenty years ago in this evaluator's experience. Eighty-one percent of births are attended at home under the supervision of a family member or a traditional birth attendant (TBA). Yet MOH personnel have a high level of distrust of the TBAs. (Refer to the data on page 14, Section 3.) The MOH physicians and nurses are making a big push to have the mothers deliver at the health post. Travel to the health post, however, during late stages of pregnancy is very difficult on mountain paths. Mother feel safer and more secure at home.

The project has four interventions: pneumonia case management (PCM), diarrheal disease control, nutrition/growth monitoring, and maternal health/obstetrical emergency management. It has two broad strategies: 1) to improve the coverage and quality of health services al all levels by training MOH staff and community volunteers, (called Promoters), and, 2) to improve the home care of children through the recognition of danger signs and prompt seeking of appropriate care. The Promoters should supervise all at-risk families. Each Promoter has no more than twenty families under his care.

Progress by Interventions: PCM

The strategy for introducing interventions in this project is to begin with pneumonia case management in Year One, and then add maternal/obstetrical care, diarrheal disease control and nutrition/growth monitoring one year at a time. At the time of the mid-term evaluation the project has been working on PCM for a year and a half and has introduced maternal care on schedule.

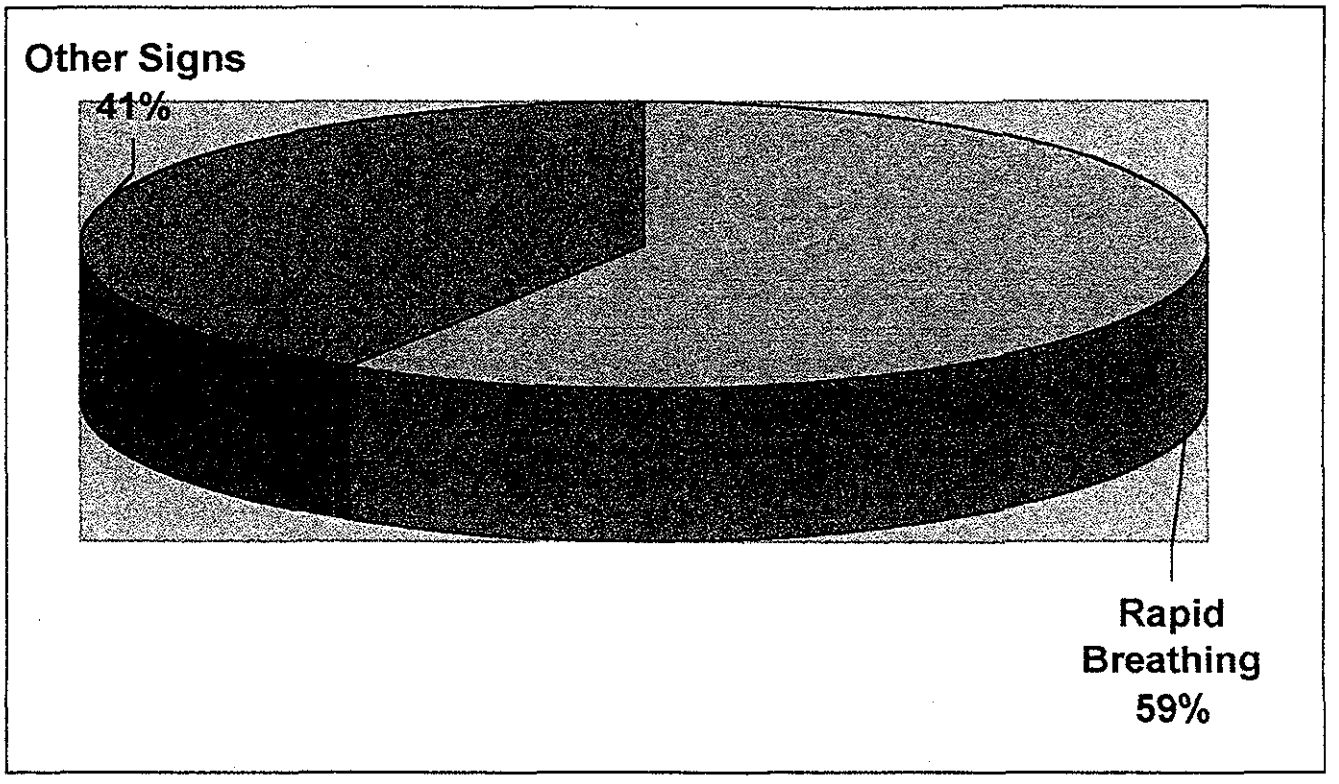
All of the Promoters have been trained in PCM. They have been trained to recognize signs, advise the mothers in the immediate care of their sick ones, make referrals, and follow up counter-referrals. The Project Director is working with the MOH to introduce a pilot-project for training a selected group of Promoters to manage pneumonia on their own with sulfa drugs. The Esperanza Program Director and the Project Director should pursue this option aggressively with the MOH. In the experience of this evaluator, Promoters are able to provide PCM and save lives. In a recent evaluation in Honduras, over 100 health volunteers provided PCM with zero deaths of children under their care. The evaluation team found no evidence of misuse of medicines. This strategy is desperately need in the area where the project is located.

The health messages about respiratory infections have primarily been communicated by the Supervisors through the medium of home visits. Mothers in all 140 communities have been reached by the mid-term. This is commendable; given the difficult terrain and the fact that most of the work has been done on foot. In the future, however, the

Supervisors need to focus their attention on working through the Promoters, and having the Promoters be the ones who interact with the mothers.

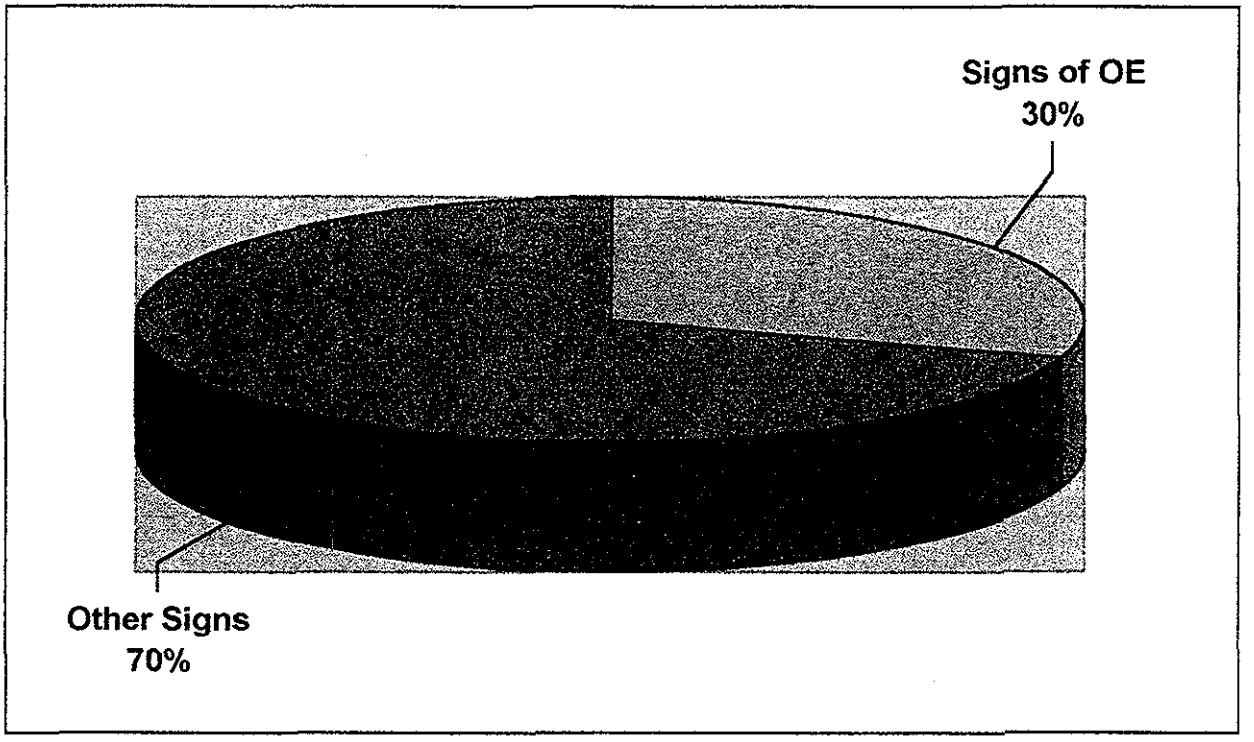
As part of the mid-term evaluation the team conducted a local rapid assessment of mothers' knowledge of the signs of pneumonia and of their health-seeking behavior. A total of 221 mothers were interviewed from each of the project's seven zones. The following chart presents the results. The importance of this finding is that 59% of the mothers correctly identified rapid breathing at rest as the only sign from a menu of options. These mothers excluded signs such as headache and convulsions from their choices.

Chart 1: Percent of Mothers Who Identified Rapid Breathing as a Sign of Pneumonia
N= 221



The evaluation team also asked mothers to identify the signs of obstetrical emergencies. They were asked to choose from the signs of anemia, hemorrhaging, colds, placenta retention and inebriation. The following chart presents the percent of mothers who correctly identified only hemorrhaging and placenta retention as sign of an obstetrical emergency.

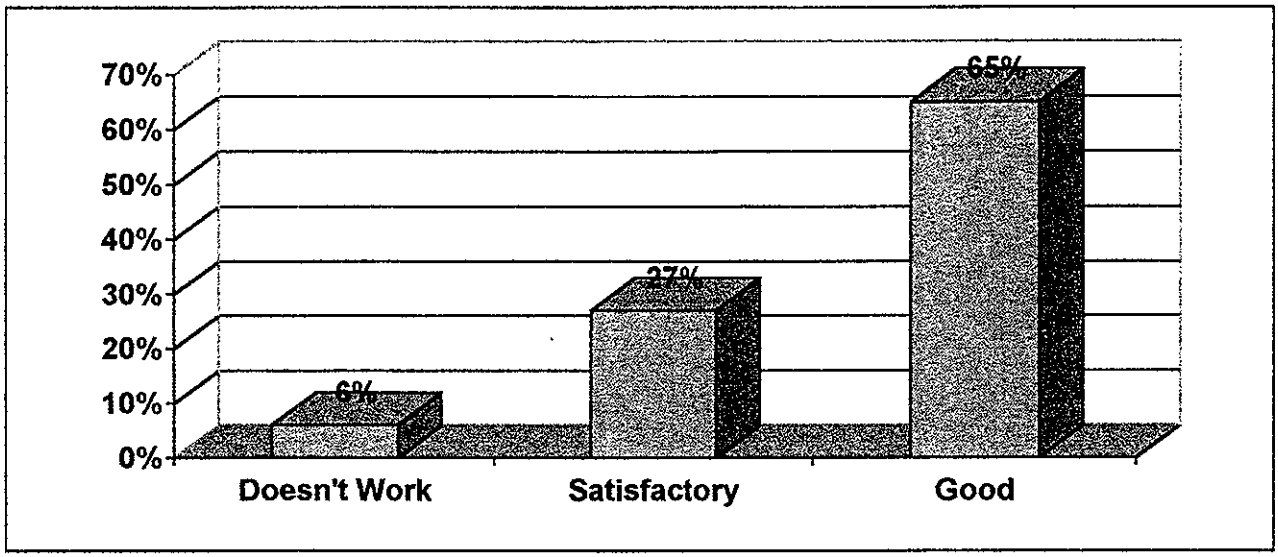
Chart 2: Percent of Mothers who Identified the Signs of Obstetrical Emergencies (OE).
N= 221



This represents the result of six months work in communicating this message. Given the high illiteracy rate (65%) and the isolation of the villages, the project team has made good progress. As in the messages regarding pneumonia, this progress is primarily due to the work of the Supervisors through their home visits.

The project team recognized that there has been a high turnover rate among the Promoters and that they have not worked with mothers as intensively as planned. Thus the evaluation team was interested in knowing if the mothers knew who their promoters were and how they perceived the value of their work. Eighty percent of the mothers knew their promoter's names. (In one case a mother teased the interviewer by saying that she did not know the promoter's name, when in fact the promoter, who was standing nearby, was her husband!) Additionally, the mothers were asked to rate the value of the promoters' work. The following chart presents the results.

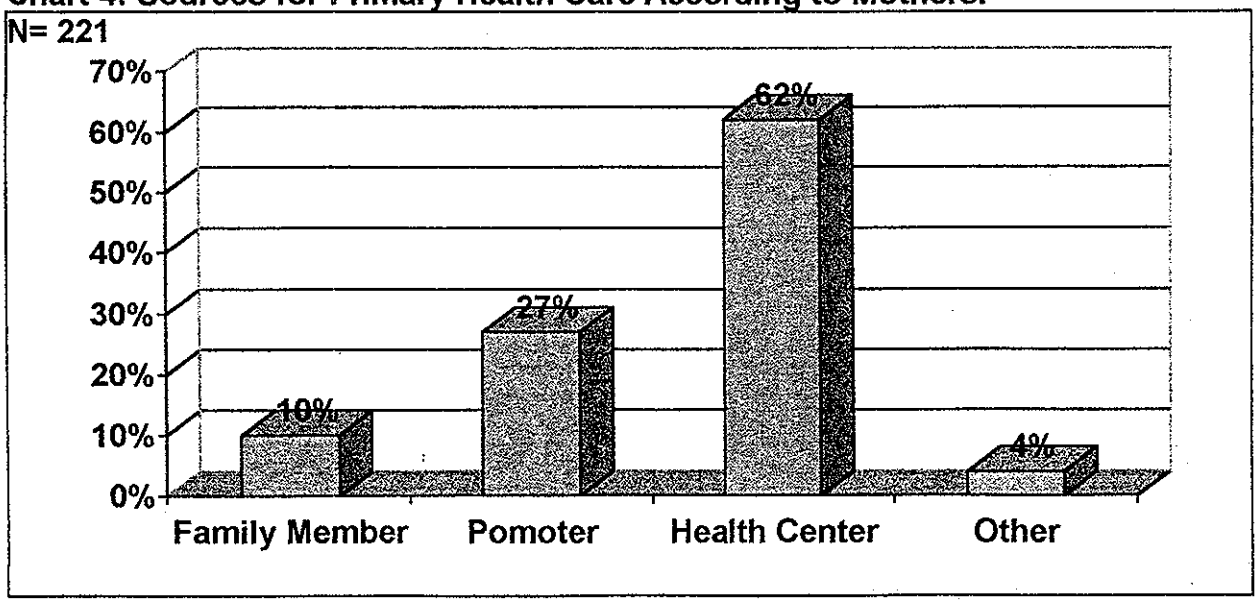
Chart 3: Mothers' Rating of the Health Promoters.
N= 221



This finding is better than expected, according to the project staff. It may be that the mothers' regard for the work of the Supervisors influenced their view of the Promoters. Nevertheless, it will be important to communicate this finding to the promoters. It also provides a positive indicator that mothers will receive the increased intervention by the Promoters, with a corresponding decrease by the Supervisors, in a positive manner.

While the mothers may appreciate the promoters, they do not regard them as the primary care agent in the community. Mothers were asked to identify whom they would go to first if their child were sick. The following table presents the results.

Chart 4: Sources for Primary Health Care According to Mothers.



This finding identifies a critical area of concern. Especially in this project area it is important that the Promoters be regarded as the first line of defense against illness. The distances that most parents have to walk to reach the health center do not make it a realistic first choice. Because of the difficult circumstances, parents tend to delay taking a sick child to the health center in hopes that the child will get better on his own. Consequently, children's illnesses tend to be in advanced stages and their care is more complicated. The project staff need to work more closely with the Promoters to expand their training and to elevate their status in the community.

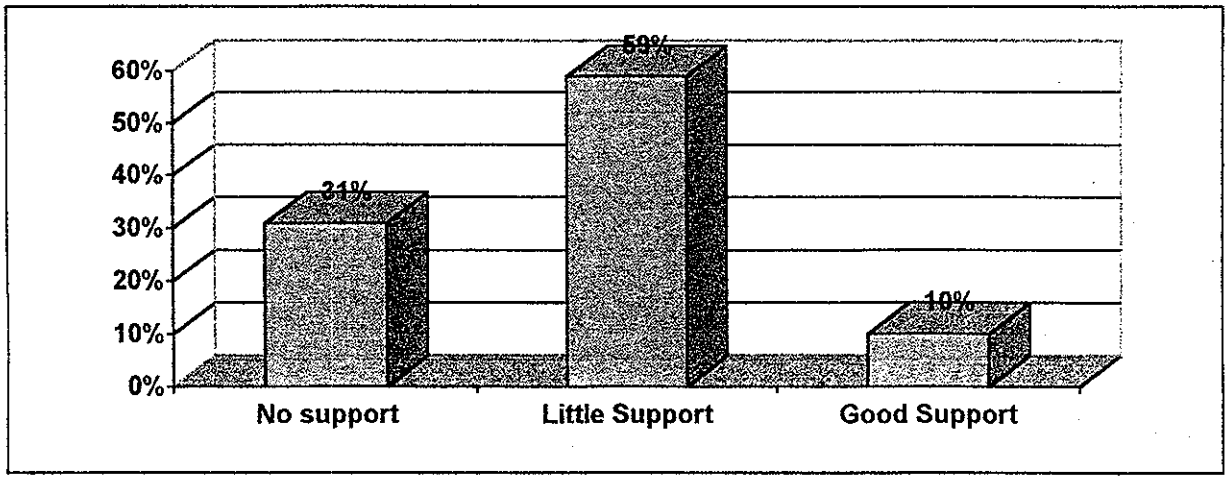
Health educational materials have been designed and tested for use in the project. The staff have created posters with visual images of the key health messages to give to mothers and they have created flip charts for the promoters. Unfortunately the process of developing these tools has taken almost two years. As of the mid-term neither of these resources have been distributed. An unfortunate series of events have led to the delays, however, only two years are left and it is urgent that these materials be put into use. New educational materials that are developed for the future need to be developed and put into use in a more expeditious manner. The process for validating new educational materials must be shortened. There is no longer time for an ideal validation process. One way to shorten this process is to involve the Promoters in developing educational materials. They can assist on the spot in addressing issues such as cultural equivalence, visual images, etc.

B. Cross Cutting Approaches

1) Community Mobilization

Community mobilization has lagged behind in this project. Much of the focus by the project staff has been on intervening directly with mothers. At the time of the mid-term, only three health committees have been formed. When the Promoters were asked to rate the support from the community, they responded in the following manner.

Chart 5: Promoters' Rating of the Support Received from the Community Leaders N= 29



Only 10% of the Promoters felt that they received good support from the community leaders. One would expect that after two years community support would be stronger.

When the Promoters were asked to assess how many mothers came to them when their child was sick, 83% said that few to none of the mothers came to them. Additionally, when they were asked to rate the support of the community for their activities, only 32% stated that the majority of the community supported them. These data indicate that the Promoters feel isolated and unsupported.

In part, the low support is due to the lack of stability in the presence of the Promoters. The Supervisors report that they are frequently gone from the community and the turn over in promoters is fairly frequent. On the other hand, the Promoters have been given very little materials to work with. They do not have flip charts as yet, they do not have chronometer for measuring signs of pneumonia and they have no reference materials. It is crucial that the project staff invest time with the Promoters to enhance their status in the community and that the project equip the Promoters with intervention tools and educational resources. This will help to enhance their visibility in the community; it will generate credibility and consequently stimulate the community to provide better support.

The evaluation team interviewed three health committees. The interviews had two parts. First, the team asked the committee members to role-play what they would do in an obstetrical emergency. Their performance was unobtrusively rated for the accuracy of their procedures. All three of the committees did an excellent performance, and did so without errors.

Second, the committee members were asked to identify and rank their motives for being part of the committee and to list their responsibilities and rank them according to their importance. The nominal group technique was used to process these questions.

All three committees identified community services as their most important motive for being part of the committee. While this is a response that one would expect, it is heartening to know that the committee members still have a positive attitude about service. Their attitude should also be an encouragement to the promoters. It is evidence of community support for health care activities. The project staff need to strengthen the relationship between the promoters and the committees and nurture a spirit of teamwork among them. The committees could be instrumental in helping the promoters to not feel like they are working alone.

In regards to ranking their activities, all three committees ranked attending obstetrical emergencies as their most important activity. This is evidence that the committees clearly know the purpose for which they were formed and of their willingness to perform this duty. The committees are new enough that none of the them have had the experience of attending an emergency. They are willing and ready to do so.

The project staff have made a good start with the committees that are formed. Many more committees, however, need to be organized. The staff should have time to do so, as they turnover more of the responsibility for home visits to the promoters.

2) Communication for Behavior Change

Qualitative studies have been done on all of the project's interventions in order to communicate the health messages in the Quechua culture. The issue in this setting is not just finding an equivalent word in Quechua, it is an issue of finding a cultural equivalent. For example, in regards to respiratory infections, the project staff could not find a satisfactory equivalent for intercostal retraction. One focus group member came up with an interesting phrase (*entra y sale su barriguita*), but other mothers did not acknowledge it as relating to a sign of pneumonia. Additionally, this phrase could mean any number of things, most of which are not dangerous. It is not surprising that this sign is difficult to translate. Even in Spanish speaking cultures, it is a sign that has proven difficult to communicate and assess. Thus, the evaluation team recommends that the objective for this intervention be changed to the recognition of rapid breathing at rest as the one danger sign for a respiratory infection.

Based on the qualitative studies the project team has designed posters with health messages and flip charts for Promoters to use in teaching. These instruments have undergone a yearlong process of design and validation. At the time of the mid-term evaluation, these instruments were in production, but have not been distributed in the communities. The project staff have also developed a few mini-dramas for the radio. They are being played on local radio stations that reach people who live near population centers. Radio, however, will have limited reach because the mountains impede radio signals and in many communities people do not have cash for purchasing radios and batteries.

It is admirable that the project team has been diligent in the design of their communication instruments. Unfortunately, however, it has taken half of the life of the project to do so, and thus far there is nothing in the communities. This evaluator recognizes that some of the delay is due to the distances in travel from the project site to Cusco, and that early in the project there were logistical barriers between the project site and CADEP headquarters. (Refer to Section 2. B (3) on page 10 for a discussion of this problem.) The project staff should make it their highest priority, however, to get educational materials in the hand of the Promoters and mothers.

Additionally, the project staff should train the Promoters in popular education methods such as pictures, songs, drama and puppets. Given the low literacy rate and the fact that everything is done in Quechua, these methods are ideal because they require no written words. Every learning tool can be developed originally in Quechua, thus there is no need to go through the process of validating language usage. And all tools can be developed with local materials. The Promoters cannot be effective unless they have tools to work with. Just doing home visits is not enough to keep them motivated and to

give them a sense of importance. Having a variety of creative educational tools in hand will contribute to their commitment to this volunteer job.

3) Capacity Building Approach

Strengthening the PVO Organization

One way that the project is strengthening the local organization is through training the Supervisors, who are employed by CADEP. Using the nominal group technique, the Supervisors were asked to identify the ways in which they have been equipped to do their job. The following table presents the most important things that Esperanza has done to strengthen them.

Table 1: Way in Which the Project has strengthened the Supervisors

Factors	Priority Ranking
A. Monthly technical meetings for solving problems	1
B. Freedom to be adaptable and creative in the community	2
C. Having a concrete and specific plan to guide their actions	3

The Supervisors were unanimous in their appreciation of the Project Director's (Ruth Madison) leadership. Her leadership style is reflected in the factors in Table 1, above, that have equipped them for this kind of work. It is interesting to observe how Ms Madison has balanced the ability to give the team freedom to adapt to conditions in the community and yet give them a sense that they are following a deliberate plan. If CADEP is able to retain these Supervisors after the end of the project, it will have well qualified staff.

Another way that the project has strengthened the local PVO has been to help them develop an efficient system for logistical supply of their projects. This is an important issue because it is a ten-hour drive over gravel roads from CADEP's headquarters in Cusco to the Project's office in Huaquira. One of the early barriers in the project was that CADEP was not able to deliver supplies on a timely basis. The Project Director spent a great deal of time early on in helping to create a document-based system for requesting supplies and services, processing requests and monitoring their delivery. The system that has been created for this project has been implemented for all of CADEP's projects.

The experience with this project has helped CADEP improve their financial management systems. The project has given them new tools and stimulated them to tighten their systems in other projects. According to the CADEP Director, their experience with this project has helped them learn how to manage funds from various sources. It has also given them the credibility to obtain funds from other granting

agencies. At the time of the mid-term evaluation it appeared that project funds were being managed appropriately. The project team reported that their requests for materials and supplies were attended to promptly and without second-guessing. The Project Director reported having an excellent working relationship with CADEP's chief financial officer.

Programmatically, adding a health component to their projects has strengthened CADEP. They have learned about critical interventions for the health of women and children and how to plan projects using an epidemiological approach. The CADEP Director has stated that CADEP now includes a maternal-child health component to their grant proposals.

CADEP is working on developing a long-range strategic plan. This is one area in which it would like additional assistance from Esperanza. Specifically, the Director has asked that the president of Esperanza assess their plan and make recommendations for improving it. This evaluator recommends that when Esperanza's president visits in November, he plan to spend time helping CADEP in this area.

Strengthening Local Partner Organizations

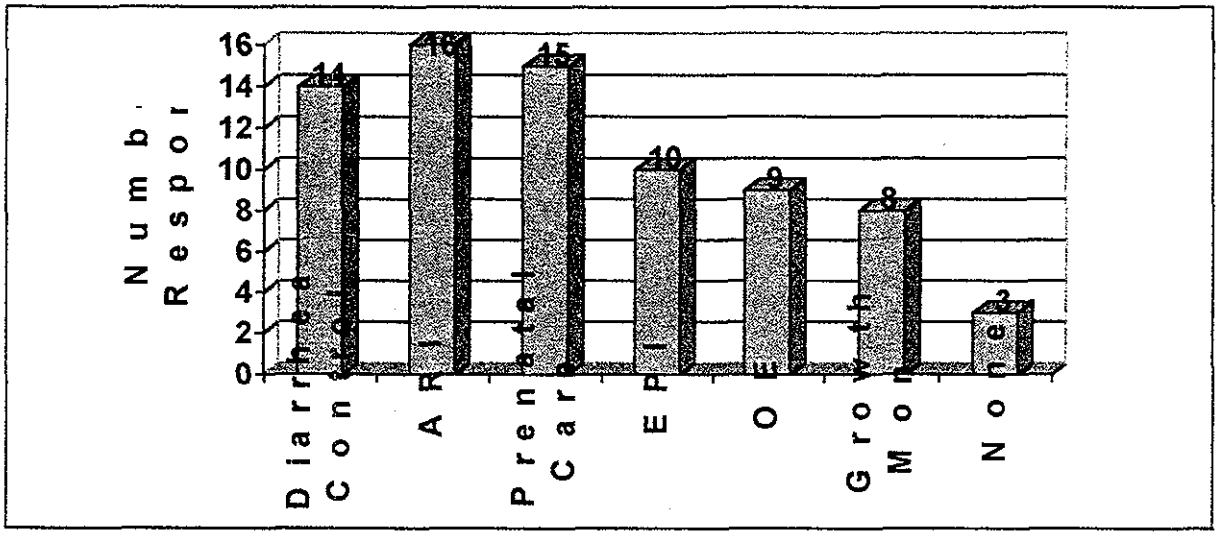
At the time of the mid-term there were no other PVO's working in the area. The only partner is the Ministry of Health (MOH). This is one of the few projects in this evaluator's experience where there is an excellent working relationship with the MOH. Ms Madison has done an excellent job in cultivating open and trusting relationship. At the regional level she has immediate access at the highest levels and has been able to gain enthusiastic support for the project. The regional authorities are aggressively recruiting Esperanza to expand their area of coverage to include at least two Provinces in Apurimac Department because of the good working relationship.

This good working relationship provides Esperanza with an opportunity to advocate for a trial project in pneumonia case management (PCM) by Promoters. This project is ideal for this program because of the high incidence of childhood pneumonia and the long distances to medical care. While the regional MOH is open to the concept, they have a very limited view of PCM. Their concept is that the Promoter gives the first dose of antibiotics and then refers the patient to the health center for the rest of the regimen. This will never work in the project area. It is not possible for most people to walk to and from the local health center in one day. Additionally, most parents state that they cannot leave their children and animals for ten days while their child is treated at the health center. If PCM is to be employed in this project, the promoters must have complete responsibility for case management. Ms Madison will need to use a great deal of her political chips to bring the MOH around to this concept. It is critical, however, that she try to do so, because there is not other way to effectively provide PCM under the conditions in this project area.

As part of the interviews with local health centers, the staff were asked to identify areas, if any, in which their coverage has improved because of their involvement in the project.

Of the 28 people interviewed, 25 identified at least one program in which their coverage has improved. The following chart presents the results from this question.

Chart 6: Programs in Which Coverage has Increased Due to the Project According to Local Health Center Staff
N= 28



The health center staff were also asked if there has been any benefit to their participation in the project, and if so, what benefit. The following table presents the highest rated benefits.

Table 2: Ways in which Health Centers have benefited from the Project
N= 24

Benefit	Rank
Increased health promotion and disease prevention activities	1
Training health promoters and TBAs	2
Increase in coverage and references	3
Increased supplies for health care	4

At the local level the project has helped trained physicians and nurses in PCM and in managing obstetrical emergencies. It has also helped the local health centers set up a system for PCM. The system includes 11 elements; from appropriate charting to maintaining a basic stock of supplies. As part of the mid-term evaluation, the team assessed the status of the PCM system in 13 health centers. The team assessed whether the status of each of the 11 elements met minimum standards. Each element was assigned a value of one, and if the element met the minimum standard, it was assigned one point. Thus if a health center met the minimum standard for each of the

11 elements of the PCM system it would receive 11 points. The result of this assessment was that all 13 centers attained an average score of 7.5 out of 11. The more important finding, however, was the identification of the health centers that received a substantially low score. For example, one health center only met the minimum standard in four of the 11 elements in their PCM system. Overall, more than half of the health centers had a score of less than 7. The Supervisors who work with these health centers should dedicate specific time to help these centers make up the deficiencies in their PCM system.

Another area of concern regarding the local health centers is their relationship with traditional birth attendants (TBA). Medical providers resist giving them full responsibility for normal deliveries. When the health center staff were asked if they were in agreement with working with TBAs, 86% stated yes (24 of 28 health center staff). On the other hand, when they were asked to identify the appropriate level of involvement, only 21% stated that it was appropriate for TBAs to do normal deliveries on their own. This is an area of concern, because there is no way that the health center staff are able to perform all of the deliveries in the remote villages. In turn, most mothers are not going to leave home for a week or more to wait for delivery in a health center. If this project is going to contribute to a decrease in maternal and infant mortality, the project team will have to work with the MOH to help them overcome their reluctance to working with TBAs.

In an interview with one physician at a local health center, it became apparent that part of the problem may be that the health center staff have not been sufficiently assured that the project will encourage mothers who live within reasonable distanced of the health center to go there to delivery their babies. The project staff should consider negotiating a written agreement (*convenio*) with each local health center that would specify the project's support for deliveries for mothers within a reasonable distance of the health center, and the health centers' support of TBAs doing deliveries in distant communities.

A final area that needs strengthened within the local health centers is the system of referrals and counter referrals from the Promoters. When the Promoters were asked how many referrals they had made in the last month, they had documentation for an average of 2.4 referrals. When asked how many counter referrals they had received, they were able to document only an average of 0.7. The project staff should help the health center staff create a more efficient system for counter referrals. If the Promoters are not acknowledged by the health centers as part of the health care system, there will not be much of a chance for sustainability.

Strengthening Health Worker Training and Performance

At the mid-term, the project has implemented two interventions, as planned: pneumonia case management and immediate care for obstetrical emergencies. The Promoters have also received some training in diarrhea control. The evaluation team assessed the

Promoters knowledge regarding the signs of pneumonia and diarrhea. The following two charts present the results.

Chart 7: Percent of Promoters who correctly identified the Signs of Pneumonia N= 29

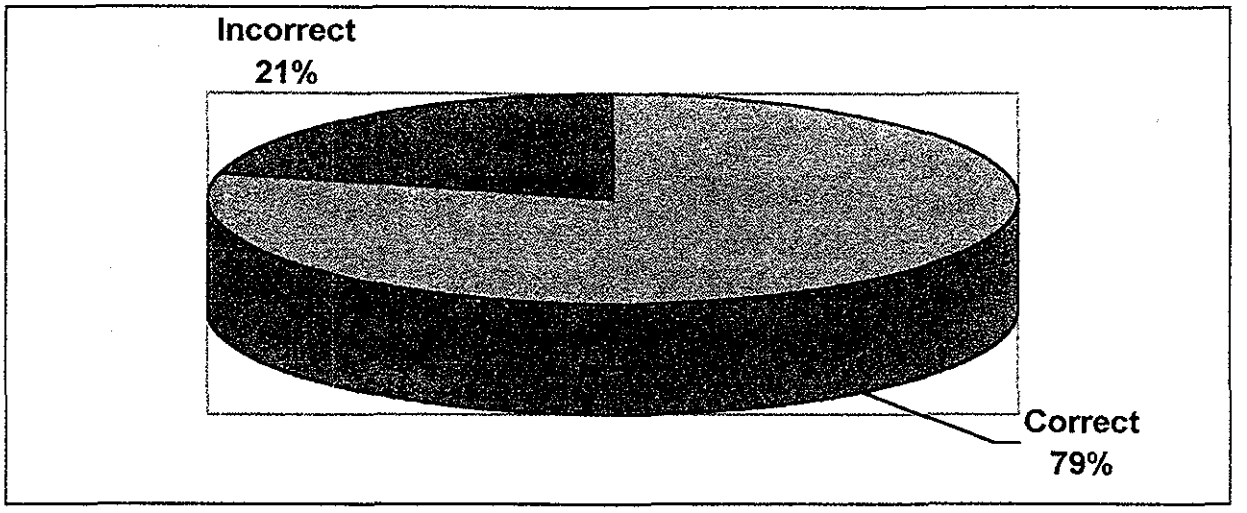
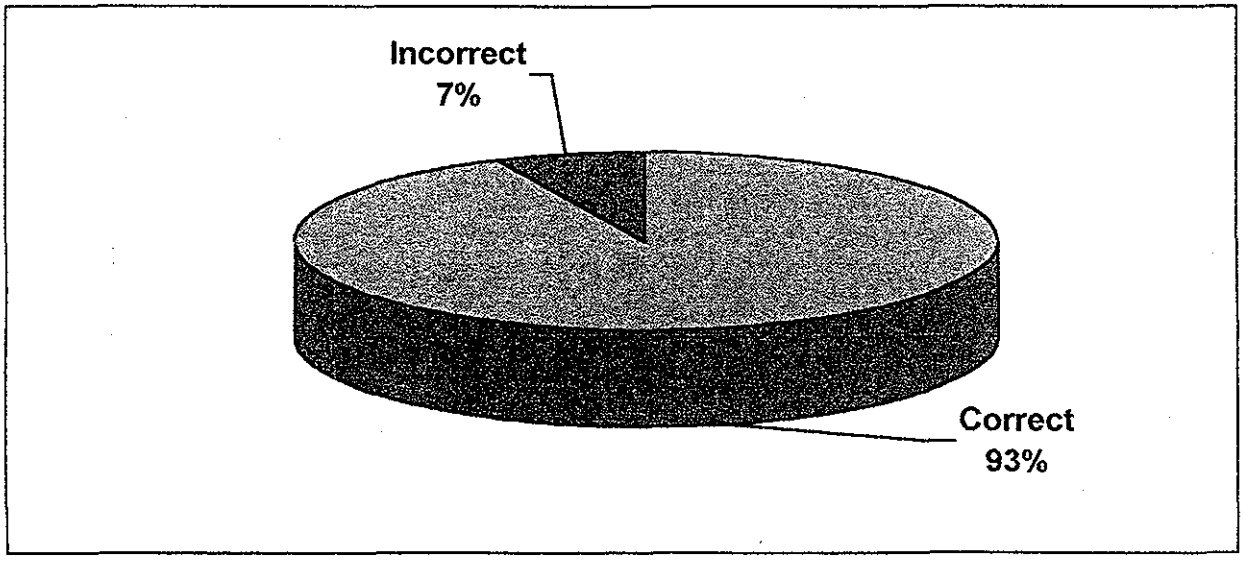


Chart 8: Percent of Promoters who Correctly identified the Signs of Diarrhea N= 29



These two charts indicate that the Promoters have a good understanding of these interventions. The limitations that arise have to do with how the Promoters carry out their duties. When the Promoters were asked what materials they had for fulfilling their role, they had nothing related to PCM, obstetrical emergencies or diarrhea control. The only "equipment" they had were notebooks, referral slips, birth and death certificates. As stated earlier, the flip charts and posters have been developed but not yet

distributed. Their primary medium for communicating what they have to offer the community is lectures. And as can be appreciated, these are not well attended.

It is critical that the Promoters have tangible objects related to the interventions that give them something to work with and give them credibility in the community. There is not much prestige in having received training in health care without tools to work with. The project team should make it a policy that Promoters receive a "tool kit" when they have finished training in each intervention. The tool kits do not need to be elaborate. For example, in PCM the tool kit could be as simple as a chronometer for measuring breathing rates, educational materials and referral slips. (Refer to page 9 for recommendations regarding educational materials.) Having basic materials to work with will provide a strong incentive for them to use their knowledge.

Mothers in all 140 communities have been reached by the mid-term, primarily through the work of the Supervisors. In the future, however, the Supervisors need to focus their attention on working through the Promoters, and having the Promoters be the ones who interact with the mothers. This will do more than anything else to strengthen the Promoters. In one sense this could be more frustrating for the Supervisors because the Promoters will not always be around when they visit, and Promoters may not be able to spend all day with the Supervisors. Thus the Supervisors may have down time and may not feel as productive. In the long run, however, this strategy will pay off because the Promoters will gain visibility and credibility in the community. And the mothers will come to identify more with the Promoters than the Supervisors, which will strengthen their role in the community.

4) Sustainability Strategy

The sustainability strategy centers on four groups of people: MOH, mothers, Promoters and CADEP staff. The only objectives specified in the DIP related to communities having a plan for emergency transport of children and mothers. At the time of the mid-term the health committees were just beginning to work on their emergency transport plans.

In regards to mothers' knowledge base, section 2.A. on page 4 discusses the level of mother's knowledge about the interventions that have been implemented to date. The prospects are good that mothers will have a fund of knowledge that will continue after the project finishes. Once the project staff expand the range of educational materials, the mothers will gain even more.

At the mid-term the support for the Promoters by the local health centers is weak. While they appreciate the promoters, they do not have high expectations. (See section 2.B. (3) on page 11.) As stated earlier, the Supervisors should place their focus on working with the Promoters and on improving their credibility with the MOH.

The local health centers have been strengthened by their participation in the project (see section 2.B. (3) on page 11). Areas that the project needs to work on are improving the local health centers' PCM system, strengthening their relationship with the Promoters and TBAs and improving the counter referral system. In addition, the Project Director should make every effort possible to create a pilot for Promoters doing complete PCM.

CADEP is another element of the sustainability plan. Esperanza has helped to strengthen them in a number of areas (see section 2.B. (3) on page 10). Areas that will need to continue developing are in implementing an epidemiological approach in their other projects and in staff development. One very helpful action could be for the Project Director to work out with the CADEP Director, a schedule for encounters between staff from all of CADEP's projects.

3. PROGRAM MANAGEMENT

A. Planning

Program planning has been carried out with the participation of CADEP and the MOH. The Project Director has been especially diligent in meeting monthly with the MOH authorities in the capitol of Apurimac. She has been responsive to their recommendations and in turn has been influential getting their approval for the project's activities.

In general, the project's activities are progressing according to plan. Implementation of the interventions is according to plan. While some of the project's inputs were delayed in the beginning because of logistical problems, these have been solved. (See section 2.B.(3) on page 10.)

B. Staff Training

The project staff are well trained and are satisfied in their job. In fact, their dedication to the job is admirable. This is very demanding work. They spend many hours a day walking just to get to the villages. More than fifty percent of the time they have to sleep over in the community that they are visiting. There is no food for purchase, so they have to carry their own. Most of the time they have no private sleeping quarters; they simply roll out their sleeping bag on the floor of the Promoter's house. One Supervisor stated that she spent 70% of her nights away from her apartment. Under these conditions it is not surprising that there has been a high turnover of staff. Thus far the Project Director has done a good job of keeping staff moral up and in providing the personal support that the Supervisors need to continue with their job.

C. Supervision of Program Staff and, D. Staff Management

The Project Director has a good system for staff supervision. She leads monthly review and planning meetings. She spends time in the field with each one every month. She uses the health information system to give each Supervisor feedback on their work and to help them set goals for the month. As stated in section 2.B.(3) on page 10, the Supervisors feel well supported in their duties.

One area that needs to be addressed is the number of communities under the responsibility of the Supervisors. The number of communities has increased since the DIP was written, from 107 to 140, an increase of 32 communities. Meanwhile, the number of Supervisors has stayed the same. This has increased the Supervisors' workload, in an area where distances are long and conditions are difficult. The Project Director and Esperanza Program Director should analyze the budget to see if it is possible to hire one more Supervisor. Additionally, they should make every effort, within the limits of the budget, to provide motorcycles for the Supervisors. This will make a dramatic difference the amount of work that the Supervisors can accomplish. This evaluator recommends that USAID expedite the transfer of the funds left over from closing the project in Honduras to this project in Peru and that some of these funds be used for motorcycles. If it is possible to purchase motorcycles, this evaluator recommends that the women Supervisors be lavished with encouragement to learn to drive. The Project Director should do everything possible to avoid the scenario of the men on motorcycles and the women walking. Women are just a capable of driving motorcycles as the men, even though some of them may not believe so. For some of the women, it may be helpful to begin practicing on bicycles and graduate to motor cycles. (Ruth, do whatever it takes!)

E. Financial Management

The expenditures for this project are on track for this stage of the project. All evidence points to good financial management. (See page 10 for more details.)

F. Logistics

Refer to section 2.B.(3) on page 10 for discussion of issues related to logistics.

G. Information Management

The current health information system gathers information on the activities of the Supervisors. It is a good system, and the information is used to give feedback and for

program planning. No data, however, are gathered regarding activities among mothers and Promoters and that relate to the project's measurable objectives.

This evaluator recommends that the information system be expanded in two ways. First, the project staff should develop a system so that Promoters are collecting a limited set of data about the at-risk families under their supervision. The fact that many of the Promoters are functionally illiterate is certainly a valid limiting factor. It is possible, however, to create a system based on symbols and line markings (*palotes*) that Promoters can use to keep track of health status data. Such a system can give the project staff an objective reading of the status of change in the community.

Second, the project staff should use the training and tools that were developed at the mid-term to continuing gathering data related to the project's measurable objectives. On a quarterly, or semi-annual basis, the team should follow up on some of the variables from the mid-term evaluation and add new ones as new interventions are implemented. For example, they should continue to monitor the knowledge, and practice, level of mothers using the local rapid assessment technique. They should continue to monitor the ratio of referral and counter referrals and the PCM system in the health centers. Using the data from the mid-term they can graphically monitor their progress. They should also be sure to share their finding with the MOH and with the communities.

H. Technical and Administrative Support

An excellent working relationship exists between the Project Director and the Esperanza Program director who is based in Phoenix. They communicate weekly via email. Reports are exchanged on a timely basis. The home office has been quick to respond to issues and concerns that are brought up from the field. The Esperanza Program Director has visited the project five times in the first two years. The President of Esperanza has visited once in June 1999, and is scheduled to return in November 1999.

This project will need technical assistance from the home office in two areas. One is technical assistance in management and administration for the Peruvian PVO, CADEP. (This request is discussed on page11.) The second is in adjusting the budget to accommodate the need for more Supervisors and to provide them with motorcycles for transportation. This evaluator encourages BHR/PVC to release the funds from Esperanza's Honduras Child Survival project to use in the project for this purpose. It would be money well spent, since this project is very well managed, and the added assistance can have a geometric affect on the effectiveness of the Supervisors who work under very difficult conditions.

4. OTHER ISSUES

No additional issues need to be discussed in this evaluation report.

5. CONCLUSIONS AND RECOMMENDATIONS

Recommendations	Person Responsible	Completion Date
1. Equip the promoters with basic educational materials as soon as possible. They should have something concrete in their hands ASAP.	Project Director, Supervisors	1 Nov. '99
2. Train the promoters in the use of popular education methods. It is no surprise that *charlas* don't go over very well. (How many of us fell asleep in class?)	Esperanza Prog. Dir., Project Dir.	1 Feb. '00
3. Change the standard for recognizing signs of pneumonia to only 1 -- rapid breathing at rest.	Project Dir.	20 Sept. '99
4. Use some of the funds from the Esperanza/Honduras project that was closed down, to purchase motorcycles for the supervisors.	Esperanza Prog. Dir. Proj. Dir.	1 Dec '99
5. Use the local rapid assessment technique to monitor progress towards meeting a set of key objectives. Don't' wait until the end of the project to assess behavioral objectives.	Proj. Dir. Supervisors	Semi-annual
6. Use a strategy of focus groups followed by local rapid assessments to make adjustments to objectives 4, 5, 8, and 10. Use the focus groups to address mis-communications in the Quechua language and the local rapid assessment to obtain a more accurate assessment of the status of these objectives.	Proj. Dir. Supervisors	Begin in October, '99
7. Develop a pictorially based registry of at risk families that the Promoters can use to track the health status of the families under their care. Keep it simple.	Proj. Dir. Supervisors	1 Dec. '99
8. Begin setting up now, systems for Promoter supervision by MINSA staff. Take into account the reality that MINSA staff will not visit the Promoters in their communities.	Proj. Dir. MINSA Provincial Dir.	30 Jan. '00
9. Implement a pilot program of PCM that is done by the Promoters. This will save more lives than anything else will.	Proj. Dir. MINSA Provincial Dir.	January,'00
10. The project should sign agreements (*convenios*) with the health centers regarding training and support of TBAs for performing normal deliveries in mothers' homes.	Project Director	January, '00
11. Each promoter should receive a "tool kit" of intervention and/or educational materials after having completed training in each intervention.	Project staff	November, '99

B. Conclusions

1. The Project Director has assembled a good team. She is an excellent leader. Esperanza should do all that it can to maintain this team and sustain their motivation under these difficult working conditions.
2. The project has made good progress to date. They should have no trouble implementing the recommendations in this report and they should have a strong finish.
3. The staff team has been diligent in reaching all of the communities in the project and working with mothers. They need to shift their focus, however to spending most of their time with the promoters.
4. The project has a good working relationship with the MOH. A strong sign of this is the request from the MOH that Esperanza expand its work to cover other provinces in Apurimac Department.
5. This project should have a PCM component implemented by the Promoters. The project Director should do all that she can to convince the MOH to set up a trial project. This will save more children's lives than anything else will.

6. RESULTS HIGHLIGHTS

Mid-term Evaluation
Child Survival XIII
Esperanza, Perú
September 1999

This project is located in the Southern highland of Perú, in the Department of Apurimac, Cotabambas Province. Identifying the project's location as being in the highlands should be taken literally! The 140 communities served by the project are located between 10,000 and 15,000 feet. They are draped across Andean mountain peaks and require hours of hiking to traverse from one to the other. The people are Quechua speakers; In fact the vast majority of women only speak Quechua. All of the project's field staff are native speakers.

The main accomplishments of the project are as follows.

1. The project staff have developed an excellent working relationship with the Ministry of Health (MINSA). While the quality of the relationships vary from health center to health center, in all cases the staff have a good working relationship. The relationships with the MOH at the Department (State) level are excellent. A strong bond of mutual respect and trust exists on both sides. The MOH has asked Esperanza to expand their involvement in other provinces of Apurimác Department.
2. Mothers in all 140 communities have been reached with the planned interventions. This is commendable given how difficult it is to reach the target communities and that the only way to reach most of the communities is on foot.
3. Mothers know the sign of rapid breathing at rest as a risk for pneumonia. The project staff have done a good job in overcoming language and cultural barriers to communicate this concept.
4. The current team of field workers (called Supervisors in this project) is well qualified and they work as a team. The Project Director has provided excellent leadership in this project. It has been difficult to find the right staff, because the working conditions are so arduous. The reason that mothers know a sign of pneumonia is because of their diligence in visiting mothers in their homes. Esperanza should do all that it can to support this team and sustain their motivation for continuing.
5. All of the Promoters have been trained in PCM and know the signs of pneumonia.
6. Ninety four percent of the 221 mothers who were interviewed rated the Promoters' work as either satisfactory or good. This indicates that they have a high level of acceptance in their communities.
7. Esperanza's local partner, CADEP, has improved its ability to administer this project. Many of the administrative problems that existed at the beginning of the project have been solved.
8. The project staff have trained MOH personnel in each local health center in the project's interventions and has helped them set up a PCM system in their clinics.
9. The three health committees that have been formed are well motivated and can clearly articulate their responsibilities.

ATTACHMENTS

A. Field Program Summary (Please complete the tables below.)

PVO/Country: ESPERANÇA/PERU Program duration (dates): October 1997 - September 2001

1. ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of Total Effort (a)	AID Funds in $ (b)
Immunization	%	$
Nutrition and Micronutrients	%	$
Breastfeeding Promotion	%	$
Control of Diarrheal Disease	%	$
Pneumonia Case Management	%	$
Control of Malaria	%	$
Maternal and Newborn Care	%	$
Child Spacing	%	$
STI/HIV/AIDS Prevention	%	$
Others (specify)	%	$
Total	100%	$

(a) Estimate the percentage of total effort (from USAID and PVO match funding) the program will devote to each intervention to be implemented.

(b) Estimate in US dollars (not in percent) the amount of USAID funding (excluding PVO match funds) the program will devote to each intervention.

2. Program Site Population: Children and Women (c)

Population Age Group	Number in Age Group
Infants (0-11 months)	1,074
12-23 Month Old Children	1,048
24-59 Month Old Children	2,924
Total 0-59 Month Olds	5,046
Women (15-49 years) (d)	6,638

(c) Estimate the number of people in the age group that the program expects to serve. Do not add annual births. If the program is phasing-in geographic areas over time, then estimate the population to be covered by the end of this funding cycle (after all areas have been phased-in).

(d) Estimate the number of women if data is available.

- Estimated annual number of live births in the site: 1,163
- Sources of the population estimates above: Peru Ministry of Health, Office of Information and Statistics (projections for 1998 based on 1993 census)

D. Program Goals and Objectives

GOALS:

1) Reduce infant, child, and maternal morbidity/mortality in the project zone

2) Facilitate sustainable improvements in the quality of health services in the project zone

3) Strengthen the capacity of our partner organization CADEP for health programming

OVERALL OUTPUTS:

1. Mothers/caretakers in the project area with increased skills to improve their health and the health of their children

2. Promoters in the project area with increased skills to support mothers/caretakers in improving their health and the health of their children

3. Communities with increased skills to improve the health of women and children

4. Health Unit staff in the project area with increased skills to improve the management and quality of technical services and strengthen their leadership role for the communities

5. MOH/Cotabambas provincial management team with strengthened skills in aspects of management for impact, such as: strategic and operational planning, project design, implementation of administrative subsystems, continuing education, monitoring and evaluation, and community participation and development

6. Our local partner NGO, CADEP, with strengthened skills for assessing needs and planning, implementing and evaluating maternal/child health projects

In the following four pages, the project objectives are presented with major inputs, outputs, and measurements, one intervention per page. It is hoped that being able to view this information for each intervention on one page will make reading easier. The numbering of inputs, outputs, and measurement correspond.

E. Program Location

The project is located in four districts of the province of Cotabambas, Department of Apurimac, in southern Peru. The four districts are Tambobamba, Chalhuahuacho, Mara, and Haquira.

Groups served by project interventions are 8,242 women of childbearing age, and 5,151 children under five years of age.

The total population of the zone is 34,343. 80% live outside of the four district capitals, many in communities that can be reached only by many hours of walking. The majority of the people are indigenous Quechua-speakers, who live by subsistence farming, with occasional income from the sale of produce or animals. Also, a significant number of men leave the zone for part of the year to work. The relatively few non-indigenous inhabitants live in or near the district towns.

The predominant religion is Catholicism, although several protestant and evangelical congregations exist.

Literacy is low. In the baseline survey, 65% of women reported that they cannot read. One MOH worker estimated that over 80% of the population of her district are totally illiterate. The National Institute of Statistics and Information places illiteracy for this region of Peru at 53%, highest in the country. The national average is 13%.

The status of women appears to be especially problematic. Domestic violence is common, and appears linked to alcohol abuse, which is reportedly a major problem among both men and women. In late 1997, our partner organization CADEP conducted a study on reproductive health issues in a neighboring province with similar demographics. 80% of married women examined in the study were diagnosed as having either a reproductive tract infection or trauma to the vagina. The cause is said to be the male custom of demanding sex and using force regardless of the woman's readiness. In a focus group discussion, women from the zone reported that no family member can be taken from the home to seek medical care without the permission of the husband.

In the baseline survey, almost half the mothers reported spending at least some time away from the house. Of those, 21% said older children or other family members care for small children while the mother is gone.

This project zone is a remote, rural area located between 6,000 and 12,000 feet above sea level. There are no paved roads in the area. Travel over the winding mountain roads is time consuming. While Tambobamba has had electricity for a few years, the other three districts were electrified only at the end of 1997. The first telephones, one pay phone per district town, were installed in November 1997. There is reasonable hope that the communication infrastructure will

continue to improve during the life of the project.

The entire project area can be considered isolated and difficult to reach for conventional services. The major constraint to project activities is geographic: the time required to reach the disperse communities.

Cotabambas has the highest infant mortality rate (118 per 1,000 live births) and maternal mortality rate (451 per 100,000) in Peru. It also has the lowest child development index, and the highest percentage (98%) of children with basic needs unmet, in the nation. (Source: Peru National Institute of Statistics and Information, 1996)

Local MOH officials report that the major causes of under-five mortality in the zone are pneumonia and diarrhea. Causes of maternal mortality are hemorrhage (31%), gestational hypertension (18%), infection (13%), trauma (13% - not further defined), and others (25%).

SEE MAPS ON FOLLOWING THREE PAGES

of pregnant women in the department are enrolled in prenatal care. In the survey, only 12.6% of the women reported that a qualified person had cut the umbilical cord at their last birth.

Again, poor supply of cards from the MOH is reported. The project will investigate the situation with the MOH, and seek sustainable solutions. Our two goals for the tetanus toxoid vaccine and prenatal care documented by card reflect our desire for pregnant women to get proper care, and the need to promote the health unit as an acceptable option for women.

The project zone has the highest maternal mortality in Peru. The focus group of mothers revealed that women avoid giving birth at health units because they are treated badly. Most births occur at home, attended by unqualified persons with whom the mother feels comfortable. The goals for recognition of obstetrical emergencies and Emergency Transport Plans are aimed at getting women promptly to emergency care. Combined with the effort to promote prenatal care, the emergency plans are intended to resolve the access issues for as many women as possible.

G. Program Design

CHOICE OF INTERVENTIONS

The project will work in four interventions: nutrition/growth monitoring, control of diarrheal disease, pneumonia case management, and obstetrical emergencies. These interventions were chosen for the following reasons.

(1) Malnutrition contributes to over 70% of childhood deaths. The Pacfo and PAMFAR food supplement programs have good coverage, and provide an opportunity for greater sustainable impact by strengthening existing MOH nutrition activities. (2) Pneumonia and diarrhea are the two main causes of infant mortality, which is the highest in Peru. (3) Maternal mortality in the zone is the highest in Peru. The new health facilities being built provide the opportunity for the project to help ensure sustainable emergency obstetrical services for the first time in the zone. Previously, women with obstetrical emergencies had to be transported to Cusco, at least seven hours away.

Immunization was not included because the MOH reported that coverage in the zone is good, and viewed other programs as higher priority. Though micronutrients (vitamin A, iron, iodine, and fluoride) are covered by the Pacfo program, effort will be made to increase vitamin A consumption through home gardens. Iodized salt is used widely. Though breastfeeding is virtually universal, appropriate weaning will be included in the nutrition intervention. Family planning was not included due to its extreme political sensitivity at present (Please see Section B). Malaria and HIV are not problems in the zone. IMCI is not being implemented yet.

The four interventions in the proposal have not been changed.

STRATEGIES AND ACTIVITIES

The two broad project strategies are

1) to improve the coverage and quality of health services at all levels by training MOH staff and community volunteer Promoters, and

2) to improve the home care of children, the recognition of danger signs/emergencies, and prompt seeking of appropriate care by training caretakers and communities.

These strategies will be addressed using two main lines of action: training and communication.

Design of training at all levels will be based on the Behavior Change Communication model as presented in *Communication for Health and Behavior Change*, referenced in Section N. The focus is on observable behavior and skills training. For each intervention, the five steps of (1) assessing behavior, (2) planning for behavior change, (3) skills training, (4) monitoring behavior change, and (5) maintaining health practices, will be followed.

Project objectives will be converted to their component behavioral objectives (target behaviors) and instructional objectives. To help ensure that training is consistent with the project goals, Mager's (referenced in Section N) method for developing instructional objectives will be used. This process will be applied for each level of personnel to be trained: mothers/caretakers, Promoters, MOH personnel. It will also be applied to project staff as part of the preparation phase for each intervention.

The instructional objectives for each level of personnel will form the basis of the training curricula, which will consist of the instructional objectives and corresponding training session worksheets. Training session worksheets are based on the Behavior Change Communication model of skills training in five steps: (1) instruction, (2) demonstration, (3) practice, (4) feedback/reinforcement, and (5) homework. They provide a step by step guide for the facilitator of the training session. This detailed planning of training sessions, whether individual or group, improves the quality and uniformity of project instruction and facilitates monitoring.

The communication media mix will include interpersonal and print communication channels. Broadcast is not a strong option as radio has very low penetration in the project area..

Communications materials will contain the project's standard massages, and will reinforce target behaviors including appropriate home care for diarrheal disease, recognition of danger signs for pneumonia and dehydration, exclusive breastfeeding to six months, appropriate weaning foods, appropriate use of food supplements, the importance of growth monitoring, and the recognition and appropriate referral for obstetrical emergencies.

The communication campaigns for diarrhea, pneumonia, and nutrition will target the community at large, especially husbands/fathers, since there is evidence that influence from non-caretakers is important in decision making, care-seeking behavior, and home care practices.

The obstetrical emergency intervention will need to utilize other types of communication, especially one-on-one counseling by health workers, since the audience is much smaller than that for child care. The WARMI method of planning for referral and transportation of obstetrical emergencies will be used in priority communities with poor access.

Specific training/communication tools to be used include the following:

The WARMI method, developed by Mothercare, will be used to facilitate the development of emergency plans for transporting women with obstetrical emergencies, and severely sick children, to a health facility.

The cassette forum - Audio cassettes with stories are developed that illustrate a message. The health worker has an accompanying script that he/she follows, stopping the tape at critical points for group discussion. The method offers the advantage of the unchanging content of the cassette, interaction with the audience, low cost, portability, ease of reproduction. The materials can remain available for years.

The informative home poster - These will be designed and tested to transmit the core content of the interventions. They will be distributed by Promoters and placed on walls in homes. The Promoters will orient family members to the message and use of the posters. The same posters will also be placed in health facilities, where MOH personnel will use them for education of caretakers, thus providing reinforcement of messages. The posters can also be used as visuals in training, mothers' clubs, and community meetings where the project presents its messages. Appropriateness of literacy level is crucial here.

In spite of the relatively high initial cost, the posters offer several advantages. If resources are limited, they can be targeted to higher risk households and those without access to services. Experience shows that posters self-target in the sense that the poorer the household, the longer the poster tends to stay on the wall. They serve as a long-lasting visible reference for the mother. This is especially important because the information on the poster may not be needed until long after it is placed in the house, when a child becomes ill or old enough to be weaned. The posters also help counter inaccurate information or negative messages mothers may receive from others.

The informative poster, the cassette forum, and the WARMI method have been used successfully in our projects in Bolivia, in Spanish and Quechua. Our Bolivia Country Director and her staff will provide technical assistance in adapting these tools for the Peru project.

Mother's Clubs, literacy training, counseling, and the family garden are other means by which the project will communicate its content and messages. Once developed, the various health messages will be used in all training and communication by Promoters, MOH personnel, and project staff. This consistency and repetition will reinforce the project interventions.

I. Partnership

Public Sector

The Peruvian Ministry of Health implements primary health care activities in the project area.

The planning of the project has been coordinated with regional, sub-regional, and local levels of the MOH from the proposal writing stage. Visits to regional and/or sub-regional authorities are made by Esperança headquarters staff on all visits. The project director has been coordinating closely with the local MOH Director, and has established a productive working relationship.

MOH infrastructure in the project area includes four health centers staffed by physicians and support team, and nine health posts staffed by nurse auxiliaries. Total MOH staff in these facilities includes four physicians, three nurses, four nurses midwives, 33 technical nurses, three sanitary technicians, one laboratory technician, one pharmacy auxiliary, one sanitary auxiliary.

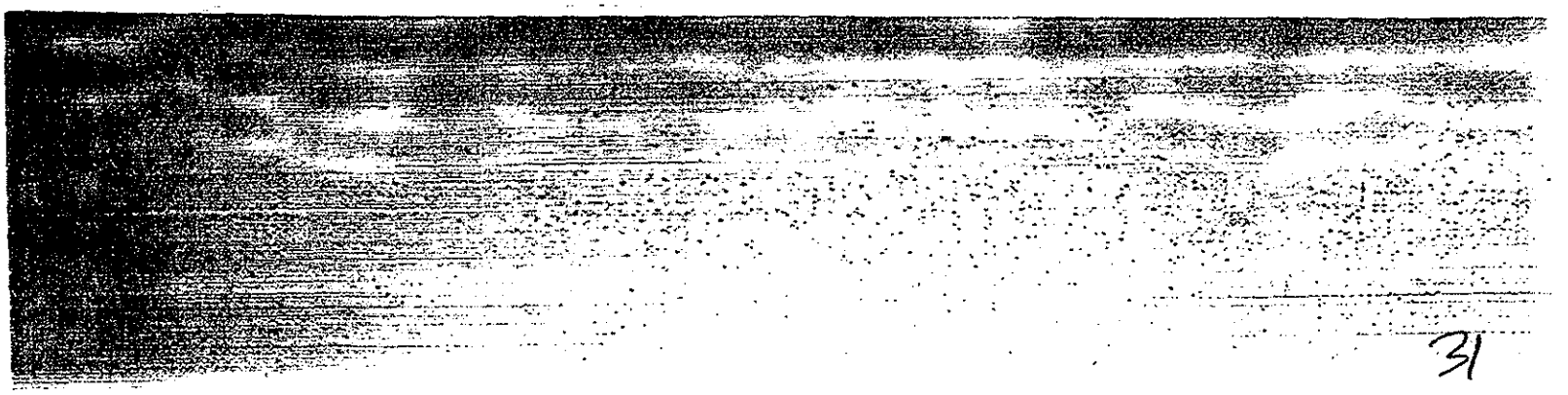
Two new health facilities have been built in the project area but are not yet operational. It appears that neither will be a fully functioning hospital. Nevertheless, they represent in improvement in the health infrastucture.

After assessing quality of care and management capacity of the local MOH system, the project will design implement and monitor activities to increase technical skills and managerial capacity. These activities will follow the project's training methodology of formulating objectives for desired outcomes, and converting these to behavioral and instructional objectives around which training activities will be designed. Project staff who have worked in the MOH system report that training is focused on diarrhea and respiratory infections, and is minimal in other areas.

Both departmental and local MOH officials and staff are receptive to the project and the concept of improving their services.

Local Partner

Esperança's partner for this project is the Centro Andino de Educacion y Promocion "Jose Maria Arguedas", CADEP. Created in 1984, CADEP is the successor to the Centro Basico de



Educacion Rural. CEBCAR. a Catholic NGO which began working in the region in 1968.

Based in Cusco. CADEP works in several rural provinces in the west of the Department of Cusco and the east of the neighboring Department of Apurimac. Their three main work areas are sustainable economic development. environment. and democracy. with a focus on empowering communities to manage their own resources in these areas. CADEP gives priority to three overlapping constituent groups: campesinos. women. and indigenous people.

CADEP has approximately 70 employees.

CADEP recently completed a project to train traditional healers (Hampiq Runas) in growing medicinal plants. Some of these trained healers will be recruited as promoters for the child survival project, which will form the basis of CADEP's health sector.

With the exception of the Project Director. all project staff are considered employees of CADEP and are included in their administrative system. This is the first step toward integrating the project into the CADEP structure.

CADEP will soon begin a strategic planning process, which will provide the opportunity to include health for the first time in the organization's long term vision.

CADEP is currently passing through a transitional phase. Since the proposal was submitted. there is a new Executive Director who has an understanding of community work and is supportive of the project. One of his first tasks was an evaluation of all personnel, which resulted in several changes that have caused some resentment among staff. At the same time, our Project Director is attempting to integrate the project into the CADEP administrative system. which is proving problematic. At this point, although CADEP, including the outgoing and new Directors, is committed to using the child survival project to build its health programming capacity. the organization must first deal with internal issues and attain a measure of stability before specific steps can be planned for the process of institutional strengthening for health programming.

NGO's

Caritas operates an evangelization program in Cotabambas province that includes child nutrition monitoring and food distribution. Activities are carried out by 55 promoters, all of whom are women. Promotors are trained in breastfeeding, growth monitoring, EPI, CDD and ALRI, although training is not standardized. There is no formal agreement of cooperation between Caritas and the MOH. Although some collaborative efforts have been made, coordination has not always been productive, and the relationship does not seem strong.

The **organization of traditional healers** (Hampiq Runas) focused on the previous garden project implemented by our partner CADEP. They appear loosely organized. and at this time it is

L. Health Information System

In her previous position, the Project Director had responsibility for the HIS, which was computerized. In addition, Esperança technical assistance staff in Bolivia and Brazil have extensive experience with HIS.

As described in the previous section, project information will flow through the social network that includes project staff, MOH staff, Promoters, and community members. Regular contacts will provide the occasions for collecting data and feeding it back to our various counterparts.

The local MOH denies having census data for the zone, saying a 1996 census report was taken by an official who transferred out of the area.

MOH policy is to keep information generated by Promoters in a parallel system. MOH will soon implement a notebook system with Promoters for them to record their work data. Health staff are responsible to collect this information, which will also be used by the project to monitor the work of Promoters.

The following data will be collected to monitor the project activities:

TRAINING

The quality of all project training will be monitored project staff observation of sessions using checklists, post-training observation of skills at all levels, interviews/focus groups in homes with mothers/caretakers, and observation and record review in health units.

NUTRITION

data	collection
# Promoters and MOH staff trained	from project records - monthly when training is in progress
# mothers/ caretakers trained	by project staff fro Promoters notebooks - monthly when training is in progress
# children registered in growth monitoring and with growth cards	collected by MOH and project staff from growth monitoring cards and mothers' groups - quarterly
# children weighed per month	collected by MOH and project staff from Promoters' notebooks - monthly

# children malnourished	collected by project staff from Pacfo records and growth monitoring cards - quarterly
# children enrolled in PAMFAR that improve every six months	from PAMFAR records and growth monitoring cards - six month intervals
Quality of growth monitoring and counseling	observation of Promoters and interviews with mothers by project staff - bimonthly
# family gardens and consumption of Vit A foods	collected by Promoters through observation and interviews with mothers/caretakers - bimonthly

DIARRHEA

data	collection
# Promoters and MOH staff trained	from project records - monthly when training is in progress
# mothers/ caretakers trained	by project staff fro Promoters notebooks - monthly when training is in progress
Quality of home case management	collected by Promoters through interview of mothers/caretakers of children with diarrhea and observation in homes - per case
# children appropriately referred to health unit	collected by project staff from health unit records - bimonthly
# packets of ORS distributed by Promoters	collected by project staff from Promoters' notebooks - bimonthly
# of children who receive more food for two weeks following diarrhea	collected by Promoters through observation and interview with mothers/caretakers - per case

PNEUMONIA

data	collection

= Promoters and MOH staff trained	from project records - monthly when training is in progress
= mothers/ caretakers trained	by project staff fro Promoters notebooks - monthly when training is in progress
Prompt referral to appropriate provider of SCM	monitored by Promoters trained in SCM through examination of child when brought by mother/caretaker, by health unit staff also through examination of child, and collected by project staff from Promoters' notebooks and health unit records
Quality of SCM administered by Promoters	monitored by project staff using Promoters notebooks, review of health unit records, and interviews/focus groups with mothers/caretakers
Quality of SCM administered by mothers/caretakers	monitored by trained Promoters during follow-up home visits, collected by project staff from Promoters' notebooks
Function of Emergency Transport Plans	monitored by project staff through interviews with Promoters and community members after occasions when plan has been used and review of records at unit to which child was taken

MATERNAL HEALTH/OBSTETRICAL EMERGENCIES

data	collection
# Promoters and MOH staff trained	from project records - monthly when training is in progress
# mothers/ caretakers trained	by project staff fro Promoters notebooks - monthly when training is in progress
# women who have Maternal Health Cards	monitored by Promoters through mothers' groups and home visits, collected by project staff from Promoters' notebooks

EVALUATION TEAM

Lead Evaluator: Richard Crespo, Ph.D.

Team Members:

Reese Welsh, Program Director
Ruth Madison, Project Director
Arturo Palomino, Staff Coordinator
Salomé Ccasani, Supervisor
Juvenal Bautista, Supervisor
Justina Carrión, Supervisor
Nancy Trujillo, Supervisor
Jesús Huaripuma, Supervisor
Bertha Cáseres Valencia, Administrative Assistant
Alfredo Huaccac, Driver
Vicente Huallyapuma, Driver

ASSESSMENT METHODOLOGY

The evaluation team used a combination of methods. For interviewing mothers, we use the local rapid assessment technique to assess their knowledge about the signs of pneumonia and obstetrical emergencies, and to inquire into their support of the Promoters. The team interviewed 221 mothers.

With the Promoters, the team used a questionnaire to assess their knowledge regarding pneumonia and diarrhea control, and to gather their perceptions about support from the community and the health centers. Additionally, where we were able to gather a group of promoters, we used the nominal group technique to obtain information about their motives for serving as promoters and their perceptions about support from the community. The team interviewed 29 Promoters.

With the local health center staff the team used a questionnaire to identify their perceptions about the project, about the work of the Supervisors, Promoters and TBAs. The questionnaire used a combination of rating scales, Likert scales and scoring forms. The team interviewed 29 health center staff.

With the health committees the team used a combination of role-playing and the nominal group technique to assess their knowledge of obstetrical emergencies and obtain their perceptions of their responsibilities. The team interviewed three committees.